

Case Number:	CM14-0098969		
Date Assigned:	10/14/2014	Date of Injury:	01/10/2013
Decision Date:	11/13/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/27/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Injured worker is a male with date of injury 1/10/2013. Per primary treating physician's progress report dated 5/2/2014, the injured worker complains of pain and discomfort in the cervical spine that he describes as sharp, stiffness, aching and soreness in nature which radiates down to both arms and hands. He rates it at an 8-9/10. He is complaining of pain and discomfort in the lumbar spine that he describes as sharp, stabbing, stiffness and aching in nature with radiation down to both feet and legs. Per the pain diagram, he indicates that there is a burning sensation in the cervical, thoracic and lumbar spine, head and bilateral upper and lower extremities. On examination there is tenderness to palpation of the cervical spine and the lumbar spine. There is normal range of motion of the cervical spine with pain. There is decreased range of motion of the lumbar spine with pain and spasm. Straight leg raising test is positive with radiation of pain to the bilateral feet. There is decreased dermatomal sensation at L5 through S1 bilaterally. Diagnoses include 1) concussion 2) musculoligamentous sprain/strain, cervical spine 3) musculoligamentous sprain/strain, lumbar spine 4) 3 mm posterior and intraforaminal protrusion L3-L4 and 5 mm posterior and intraforaminal protrusion L4-L5.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

X-force stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy section Page(s): 114-116.

Decision rationale: The requesting physician explains that the X-Force stimulator is to be used for conservative care to reduce pain level. Per manufacture's information, this device is a dual TENS and TEJS unit. The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II and for CRPS I. There is some evidence for use with neuropathic pain, including diabetic neuropathy and post-herpetic neuralgia. There is some evidence to support use with phantom limb pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. It may be useful in treating MS patients with pain and muscle spasm. The criteria for use of TENS include chronic intractable pain (for one of the conditions noted above) with documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a one month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used as well as outcomes in terms of pain relief and function, and a treatment plan including specific short and long term goals of treatment. The injured worker does not meet the medical conditions that are listed by the MTUS Guidelines where a TENS unit may be beneficial. The TENS unit is also being used as a primary treatment modality, which is not supported by the guidelines. The criteria for the use of TENS specified by the guidelines are not supported by the clinical reports. Specifically, there should be documentation of pain of at least three months duration, and the injured worker has been identified as having an acute exacerbation. The criteria also include evidence that other appropriate pain modalities have been tried (including medication) and failed, of which this is not evident in the clinical documentation. These criteria also specify that there is to be a treatment plan including specific short and long term goals of treatment with the TENS unit. The request for X-force stimulator unit is determined to not be medically necessary.

Ice/Heat unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, Cold/heat Packs section

Decision rationale: The requesting physician explains that the ice/heat unit is to reduce inflammation. It is being requested for a period of 60 days for pain control, reduction of inflammation and increased circulation. The MTUS Guidelines do not address the use of ice/heat unit. The ODG recommends the use of cold and heat pack as an option for acute pain. At home local application of cold packs in the first few days of acute complaints and thereafter the

application of heat packs or cold packs is recommended. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The injured worker has been injured for over a year, and is therefore chronically injured. There is no report of recent exacerbation or new injury. The request for Ice/Heat unit is determined to not be medically necessary.